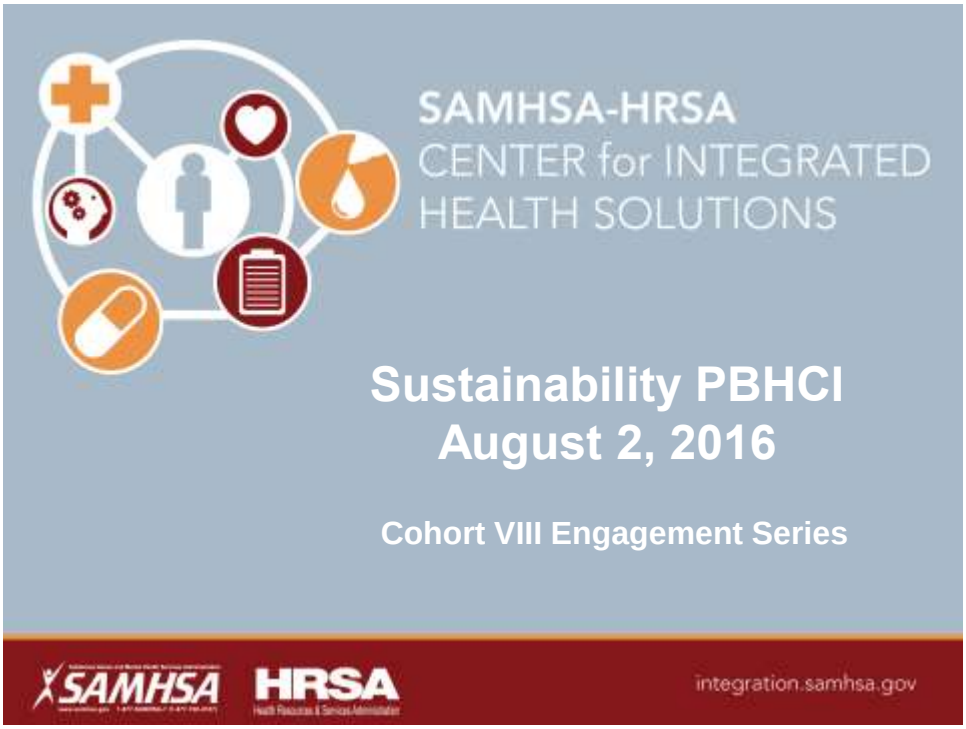


John Kern MD

Regional Mental Health Center
Cohort 2

SAMHSA HRSA integration.samhsa.gov

If you build it, they will not necessarily come…

Putting co-located primary care provider in place → Very little business!

Why not?

- Separate FQHC registration a significant barrier.
- It turns out staff are needed to shepherd the transition, even in the same office suite.
- All CMHC staff didn't have message repeated and repeated and repeated…
- What seems like a lot of CMHC patients is a trickle for the FQHC!

Looking past grant to sustainability

- Home Health Amendments, becoming Patient Centered Medical Homes
- FQHC & other primary direct services

→Thinking about clinical flow in a merged agency

SAMHSA HRSA integration.samhsa.gov

We went the FQHC route

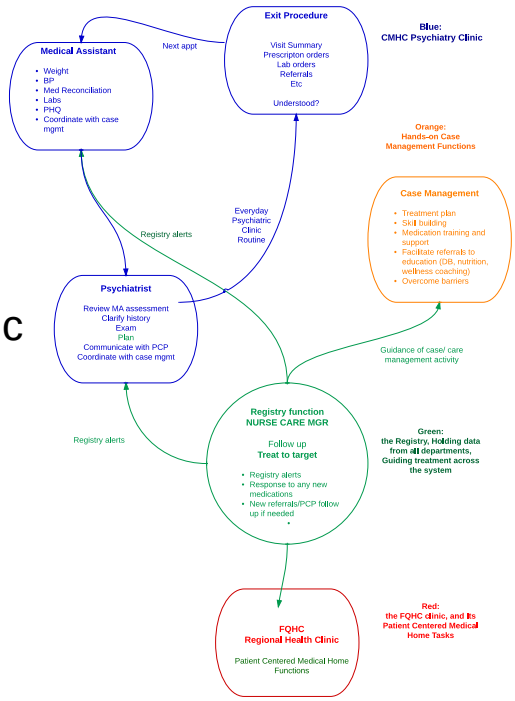
REGIONAL HEALTH CLINIC

Healthy Bodies. Healthy Minds. Healthy Communities.

SAMHSA HRSA integration.samhsa.gov

One outcome of PBHCI:

PBHCI functions become psychiatric "Business as Usual", including Primary Care.



SAMHSA HRS

The Family and Social Service Administration (FSSA)

The Indiana State Department of Health (ISDH)

PRIMARY CARE BEHAVIORAL HEALTH INTEGRATION (PCBHI)

OVERVIEW

DECEMBER 9, 2014

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About Richmond Behavioral Health Authority (RBHA)

- Local Authority - provides Mental Health, Developmental Disability, Substance Use Disorder, Emergency and Prevention services for the City of Richmond, Virginia
- Served approximately 5% (+11,000) of the City's population last year
- Known in the community, historically, as a behavioral health and developmental disabilities services provider
- Just entering year 4 of our 4-year PBHCI grant - Richmond Integrated Community Health program (***the RICH Clinic***), a project that has turned out quite successful for us.

Recent Health Care Environment in Virginia

- Virginia is a non-Medicaid Expansion state; almost half the people we serve have no money or insurance
- Virginia has defaulted into the healthcare.gov exchange rather than creating its own exchange
- Policy makers in VA have been (and still are) developing a managed care model for indigent care
- Resources vary wildly between rural and urban areas; RBHA has robust continuum of behavioral health services
- Potential for institutionalization of CCBHCs in VA; planning grant is underway and potential demonstration grant application is in development

The Path to RICH Recovery at RBHA

- Prior to PBHCI grant, clinic began small - 1 day per week clinic serving small portion of our population, contracting with a local FQHC for the medical services (1 NP for 6 hours per week);
- Later expanded to two partial days per week, for total of 8 hours, serving a maximum of about 80 people;
- July 2013: **RBHA awarded $1.6 million**, 4-year grant from SAMHSA
  - Designed to **expand** RBHA's on-site **primary medical care clinic for persons with behavioral health disorders**
  - Became a **directly-operated, full-time clinic**, staffed by RBHA doctors, nurse practitioners, nurses, care coordinator and peers

Sustainability is Job One, on Day One

- Very intentional plan to ensure long-term viability / sustainability was launched once we received the grant, with several major components:
  - Internal marketing campaign designed to "sell" this service to the staff of the organization;
  - Cross-divisional implementation work group work group established to secure "buy-in" from all parts of the organization: (1) renovation and equipment; (2) staffing and recruitment; and (3) evaluation planning;
  - Major "Grand Opening" events were planned from day one, even though it was almost a full year later that full scale clinic opened its doors;
  - Billing for services: standing agenda item for team meetings

Sustainability as Increasing Priority and Bigger Challenge during the First Year

- Discussed the need to bill for every service we provided; new problems/challenges quickly arose:
  - Payers only "knew" us as a behavioral health provider
  - Internal challenge; credentialing staff had no experience with credentialing primary care staff;
  - Biggest challenge: Recently purchased (launched a year before grant) EHR system was designed for behavioral health services and didn't have modules / capacity for primary health care service documentation or billing;
  - We had no one on our staff with medical services coding expertise;

Payer-Related Challenges

- Changing the perception of RBHA as a *behavioral health* provider in addition to a *medical health* provider
- Need to credential staff in order to get paid
- Need to be able to document services to generate bills
- Need to demonstrate that the services are reaching the targeted population and achieving results, if we are to "sell" this service to the payers

Institutional Buy-In and Capacity Building

- Involve as many people as you can, in some way, to gain breadth of "buy-in"
- Create as many ways for staff of the organization to become involved in start up and implementation activities;
- Engage and enlist the CEO and the Board of Directors to ensure that integrated care becomes a high priority for the organization; keep them informed of all milestones achieved;
- Be sure to fully engage and enlist the assistance of your IT and EHR gurus;
- Hire a medical services coding specialist;

Relationship Building

- Invite payers, and state and local officials to your grand opening, and/ or your first anniversary (and 2nd and 3rd);
- Then invite them back, individually, for more targeted conversations to let them know what you are already doing and where you are going – that vision thing;
- Make sure your EHR can actually bill in a way that Medicaid and private payers can and will reimburse you;
- Plan to collect the necessary data to demonstrate outcomes and cost savings – who collects what and when;
- Develop a revenue monitoring and trouble-shooting team to carefully track your increasing revenue and catalogue and solve any and all billing problems; use your relationships.

Relationships Lead to Local Partnerships

- Local hospital system reached out to RBHA about our interest in a pilot project in which we would provide care for their high intensity cases (*frequent flyer list*):
  - People with frequent hospitalizations & ER visits
  - People with numerous chronic conditions
  - People with SMI and physical health issues
- Now piloting capitated pilot program with 15 of the most difficult individuals to make RBHA their health home;
- The Goals are to lower costs and improve care;
- Payer has committed to providing us 2-year claims data for these consumers, to see what we are trying to beat.

Enhanced Care Coordination in VA

- Statewide effort that embraces integrated care in order to reduce overall costs for dual-eligibles (Medicare + Medicaid):
  - Assist consumers with getting to appropriate medical appointments
  - Encourage more communication with physicians
  - Aim or goal is to avoid unnecessary use of high cost services
  - Reduction in high-risk behaviors
  - Reduction in baseline indicators for chronic conditions
  - Provides disease management education
- RBHA has decided to be out front on this effort and similar funding pilots, and be a champion for change at the state level

Payer Outreach and Systemic Change

- Payment systems are shifting from fee-for-service to a capitated, value-based, population health mindset;
- Advocate for your role as a one-stop, integrated care provider; not just behavioral health anymore;
- Corral payers for a site visit so they can see how much your program can accomplish (we built it and they came!);
- Advocate for changes that make sense in this new world (i.e., payment for same-day appointments for both behavioral and primary health);
- Be sure your staff is engaged and that you know what it costs to provide the services you currently have on line.

Takeaways

- Sustainability planning starts on day one; hoping for another grant is not a solution nor a sustainability plan;
- This is a challenge requiring *multiple* solutions, not just one – *"all plans on deck…";*
- Thinking long-term, becoming data-driven, and being able to demonstrate successful health outcomes and cost reductions are keys to getting buy-in from payers at any level;
- Being without Medicaid expansion is a high hurdle, but not a complete roadblock; we have already committed to sustaining these services after the grant;
- From the beginning, be willing to study, with data, what each services component costs and which ones you will maintain at current levels once the grant is gone.

Takeaways

- Get to know your payers and then make your case to those payers early, often, and repeatedly;
- Get an integrated EHR or make sure you have somebody who can retrofit yours to ensure successful primary medical services documentation and billing capacities;
- Primary care billing expertise is a must; if you don't currently have it, then develop those capacities as soon as possible;
- There may be systemic changes you must advocate for to make this even more feasible.

Contact Us!

Richmond Behavioral Health Authority

www.rbha.org

CIHS Tools and Resources

Visit www.integration.samhsa.gov or
e-mail integration@thenationalcouncil.org

SAMHSA HRSA Health Resources & Services Administration integration.samhsa.gov

SAMHSA HRSA Health Resources & Services Administration integration.samhsa.gov


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